WISCONSIN MEDICAID CRS BENEFIT PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR INDIVIDUAL OR NON-SPECIFIED COMMUNITY RECOVERY SERVICES PROVIDERS[1]

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Telephone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the local CRS benefit administrative agency.
2. To accept the payment issued by the local CRS benefit administrative agency as payment in full for provided services.
3. To make no additional claims or charges for provided services.
4. To refund any overpayment to the local CRS benefit administrative agency.
5. To keep records of the services provided.
6. To provide, upon request by the local CRS benefit administrative agency or Department of Health Services (DHS) or its designee, information regarding the services provided.
7. To comply with all other applicable federal and state laws, regulations and policies relating to providing home and community-based services under Wisconsin's Medicaid program.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a Medicaid participant and services the participant receives from the Provider.
9. To respect and comply with the Medicaid participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to Medicaid participants **for a period of seven (7) years** and to furnish upon request to the Department, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. (For state policy related to record retention see DHS 106.02, Wis. Administrative Code.
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the CRS benefit administrative agency and upon request, to the Department in writing:

[1] Note: This agreement is intended to be used for providers who are individuals, unaffiliated with an agency or service. It is also to be used by a company or organization that provides Medicaid funded services and who are not typically Medicaid program providers and who may not be specifically listed in the Medicaid Provider's Handbook

a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

Pursuant to 42 CFR § 447.10(e), I hereby voluntarily reassign my right to direct payment from the State to each local CRS benefit administrative agency that has authorized me to provide CRS services to individual participants.

If you check yes, it means that you will receive payment from the local CRS benefit administrative agency that is responsible for the participants to whom you are authorized to provide CRS services rather than directly from the State Medicaid Agency.

☐ Yes ☐ No

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

Name – Provider (Typed or Printed)	
SIGNATURE – Provider	Date Signed
SIGNATURE – Local CRS Benefit Agency Representative (Witness)	Date Signed
Print Name – Local CRS Benefit Agency Representative	